ASSEMBLY BILL No. 591

Introduced by Assembly Member Yee

February 17, 2005

An act to amend Section 14464.5 of the Welfare and Institutions Code, relating to Medi–Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 591, as introduced, Yee. Medi–Cal: quality improvement fee.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and under which qualified low–income persons receive health care benefits. Existing law provides for the provision of Medi–Cal benefits through, among other methods, managed care plans. Existing law requires the department to impose upon each Medi–Cal managed care plan an annual quality improvement fee.

This bill would prohibit the imposition of this quality improvement fee upon any program that includes funding provided by any city, county, or city and county.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14464.5 of the Welfare and Institutions Code is amended to read:

14464.5. (a) For purposes of this article, the following definitions apply:

(1) "Capitation payment" means the monthly amount paid by the state to a designated Medi-Cal managed care plan in

exchange for contracted health care services procured by means of the Medi-Cal managed care contracts described in paragraph (3).

(2) "Capitation rate" means the per member per month rate used to calculate the capitation payments.

(3) "Medi-Cal managed care plan" means any Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), and Section 14087.51 of Chapter 7, or pursuant to this chapter, and that is also an organization that meets the criteria in Section 1396b(w)(7)(A)(viii) of Title 42 of the United States Code.

(4) "Total operating revenue" means non-Medicare amounts received by a managed care plan for the coverage or providing of all health care services, including amounts received in exchange for health care procured by means of a Medi-Cal managed care contract as described in paragraph (3). Total operating revenue does not include amounts received by a managed care plan pursuant to a subcontract with a Medi-Cal managed care plan to provide health care services to Medi-Cal beneficiaries.

(b) The department shall impose, on an annual basis, a quality improvement fee no earlier than January 1, 2005. The quality improvement fee shall be paid to the state monthly and shall be 6 percent of each Medi-Cal managed care plan's total operating revenue. The quality improvement fee shall be subject to all of the following provisions:

(1) The quality improvement fee shall be paid monthly to the state and is due within 15 calendar days following the close of each month and shall be calculated on the prior month's total operating revenue as defined in paragraph (4) of subdivision (a).

(2) The quality improvement fee shall be deposited in the General Fund.

(3) If the Medi-Cal managed care plan does not timely pay the quality improvement fee, or any part thereof, the department may offset the amount of the fee that is unpaid against any amounts due from the state to the Medi-Cal managed care plan. Notwithstanding any such offset, the methodology for

determining the fee as set forth in this subdivision shall be followed.

(4) The department shall make retrospective adjustments as necessary to the amounts calculated pursuant to this subdivision in order to assure that the Medi-Cal managed care plan's aggregate quality improvement fee for any particular state fiscal year does not exceed 6 percent of the total operating revenue for the Medi-Cal managed care plan for that year.

(5) If, on account of delay in the adoption of the annual Budget Act, or for any other reason, a Medi-Cal managed care plan is not paid by the department for a period in excess of 30 days, the payment date for the fee specified in paragraph (1) shall be extended until 45 days following the date that regular payments are resumed to the plans.

(6) On or before August 31 of each year, each Medi-Cal managed care plan subject to the quality improvement fee shall report to the department, in a prescribed form, the plan's total operating revenue as defined in paragraph (4) of subdivision (a) for the preceding state fiscal year.

(7) Any fee imposed pursuant to this section shall not be considered to be an administrative cost for purposes of Section 1378 of the Health and Safety Code, Section 14087.101, 14087.103, or 14087.105, or any regulation adopted pursuant to those sections.

(8) The quality improvement fee shall not be imposed upon any program that includes funding provided by any city, county, or city and county.

(c) (1) The department shall implement this section in a manner that complies with federal requirements. If the department is unable to comply with the federal requirements for federal matching funds under this section, the quality improvement fee shall not be assessed or collected.

(2) The director may alter the methodology specified in this section for calculating the quality improvement fee to the extent necessary to meet the requirement of federal law or regulations.

(3) If, after implementation of this section, federal disapproval of the quality improvement fee program as described in this section occurs, any fees paid by the plans to the department in any period for which such disapproval is effective shall be refunded to the plans.

(d) In addition to the Medi-Cal capitation rates that a Medi-Cal managed care plan would otherwise receive for providing services to Medi-cal beneficiaries, the capitation rates shall be increased in an amount determined by the department, subject to the following requirements:

(1) The additional Medi-Cal reimbursement provided by this section shall be distributed under a capitation payment methodology or on any other federally permissible basis.

(2) The additional Medi-Cal reimbursement provided by this section shall not supplant the payments otherwise due to any Medi-Cal managed care plan in the absence of such an additional reimbursement.

(3) Additional reimbursement provided by this section to any particular Medi-Cal managed care plan shall not cause the total reimbursement paid to that plan to exceed any applicable limit on payments as established pursuant to federal law and regulations.

(e) The director, or his or her designee, shall administer this section.

(f) The director may adopt regulations as are necessary to implement this section. These regulations shall be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this section, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall include, but not be limited to, any regulations necessary for either of the following purposes:

(1) The administration of this section, including the proper imposition and collection of the quality improvement fees.

(2) The development of any forms necessary to calculate, notify, collect, and distribute the quality improvement fees.

(g) As an alternative to subdivision (f), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this section by means of a provider bulletin, contract amendment, policy letter, or other similar instructions, without taking regulatory action.

(h) To the extent permitted by federal law, any limitation on rates to the Medi-Cal managed care plan based on Medi-Cal fee-for-service costs shall be increased to include any capitation rate increase related to the quality improvement fee in subdivision (b).

(i) This section shall become inoperative on January 1, 2009, and, as of July 1, 2009, is repealed, unless a later enacted statute, that becomes effective on or before July 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

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